

## **Major Strategic Options for the TDH Hospitals**

The following options are presented with a summary of how each of the options might affect the decision criteria.

### **Option A**

*Maintain and renovate each TDH hospital and retain management by TDH or assign management to the University of Texas Health Center - Tyler.*

Currently services at the TCID focus on outpatient care and inpatient subacute long term care for persons with TB. Acute care services such as surgery, intensive care, sophisticated diagnostics and emergency care are coordinated with other hospitals such as the University of Texas Health Center-Tyler and Southeast Baptist Hospital in San Antonio. Therefore, options needed to continue the level of service currently provided at TCID include construction of a new subacute long term care hospital, renovation of existing buildings pursuant to the Kennedy report findings (see Appendix A), or consolidation and renovation of selective existing buildings on the campus (see Appendix C).

The financial summary on the following page is presented to illustrate financial implications for the TCID.

TCID Cost Projections (Millions)									
1998 - 2017									
	Actual 1997 See Note Below	Projected 1998 See Note Below	1999	2000	2001	2002	5 Yr. Period 2003 - 2007	5 Yr. Period 2008 - 20012	5 Yr. Period 2013 - 2017
<b>Operating Cost Summary</b>									
Inpatient			\$ 12.06	\$ 12.11	\$ 12.59	\$ 13.10	\$ 74.19	\$ 92.24	\$ 116.32
Outpatient			2.03	2.13	2.24	2.35	13.62	17.39	22.19
Other			1.23	1.29	1.36	1.43	8.27	10.56	13.48
<b>Total Operating Cost</b>	\$ 14.97	\$ 14.22	15.32	15.54	16.18	16.87	96.09	120.19	151.99
<b>Method of Finance</b>									
<b>TDH Hospitals Strategy</b>									
G/R Rev. Appropriation	\$ 9.91	\$ 10.01	\$ 10.01	\$ 10.01	\$ 10.01	\$ 10.01	\$ 50.07	\$ 50.07	\$ 50.07
G/R Rev. Trans. BOH Approved	1.35	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Federal Funds	0.35	0.51	0.51	0.51	0.51	0.51	2.56	2.56	2.56
Fees and Receipts	1.59	1.80	1.80	1.80	1.80	1.80	9.00	9.00	9.00
<b>Prevent. Disease Strategy</b>	0.14	0.25	0.25	0.25	0.25	0.25	1.24	1.24	1.24
<b>M&amp;CH Strategy</b>	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
<b>Employee Benefits</b>									
G/R (Appropriated to ERS)	1.32	1.32	1.32	1.32	1.32	1.32	6.57	6.57	6.57
Fees and Receipts	0.30	0.30	0.30	0.30	0.30	0.30	1.50	1.50	1.50
Federal Funds	0.01	0.03	0.03	0.03	0.03	0.03	0.17	0.17	0.17
<b>Total Method of Finance</b>	\$ 14.97	\$ 14.22	\$ 14.22	\$ 14.22	\$ 14.22	\$ 14.22	\$ 71.10	\$ 71.10	\$ 71.10
<b>Funding Shortfall</b>	\$ -	\$ -	\$ 1.10	\$ 1.32	\$ 1.96	\$ 2.65	\$ 24.98	\$ 49.09	\$ 80.89
<b>Dispro</b>									
State	\$ 5.99	\$ 3.77	\$ 3.66	\$ 3.10	\$ 2.93	\$ 2.93	\$ 14.63	\$ 14.63	\$ 14.63
Federal	10.21	6.43	6.23	5.28	4.98	4.98	24.92	24.92	24.92
<b>Total Dispro</b>	\$ 16.20	\$ 10.20	\$ 9.89	\$ 8.38	\$ 7.91	\$ 7.91	\$ 39.55	\$ 39.55	\$ 39.55
<b>Capital Costs</b>									
<b>Option 1</b>									
Total Renovation (Kennedy Report)			\$ 25.00						
Annual Debt Service*				\$ 2.37	\$ 2.37	\$ 2.37	\$ 11.86	\$ 11.86	\$ 4.75
<b>Option 2</b>									
New Subacute Hospital			\$ 20.75						
Annual Debt Service*				\$ 1.97	\$ 1.97	\$ 1.97	\$ 9.85	\$ 9.85	\$ 3.94
<b>Option 3</b>									
Selected Renovation			\$ 10.45						
Annual Debt Service*				\$ 0.99	\$ 0.99	\$ 0.99	\$ 4.96	\$ 4.96	\$ 1.98
* Annual Debt Service is at 5 percent amortized over 15 years.									
NOTE: 1997 and 1998 amounts reflect actual and projected expenditures by source of funding on a cash basis. Some expenditures reported in 1997, benefited the 1998 period. For 1999 and later years, operating costs are projected on an accrual basis and reflect estimates of actual costs to be incurred to provide services based on the projection assumptions listed below. Funding projections for future years are shown above at the 1999 level.									

#### **Assumptions for Cost Projections:**

- **Hospitals will maintain current TB admission rates as a percentage of total TB cases in Texas.**
- **Outpatient visits are projected at 1997 levels.**
- **Average length of stay is projected to increase at 1/2% per year due to growth in MDRTB cases.**
- **The 1997 ratio of fixed and variable costs to total costs will remain consistent.**
- **Inflation is projected at 5 percent per year. (Note: Approximately fifty percent of operating costs is for salaries. Future salaries increases will depend on legislative action.)**
- **Relative source of funding is projected in proportion to 1997 actual amounts and adjusted for any changes in service mix.**
- **Actual historical DISPRO funding levels were provided by TDH staff. Future DISPRO levels are projected based on historical DISPRO payments as a percentage to total payments to the State. The actual DISPRO amount received in future years by this facility will depend on patient volumes for Medicaid patients and for patients without insurance.**
- **Any impact on this facility due to a reduction in services or due to the other TDH hospital closing, is expected to be phased in over a transitional period with the full impact not reflected in the above projections until 2001.**

**Services currently provided at the STH include both subacute long term care for TB, outpatient and inpatient medical and surgical services, and other support services. Complicated and acute care medical cases for persons with TB are being served by the UTHC-Tyler and the University of Texas Medical Branch at Galveston, with the addition of Valley Baptist Medical Center, Harlingen, and Brownsville Medical Center for other patients requiring complex medical and surgical intervention. Options to continue to provide these services consist of renovating existing facilities as described in the Kennedy report or replacing the existing facility with new hospital construction.**

**The financial summary on the following page is presented to illustrate financial implications for the STH.**

## 1998 - 2017

NOTE: 1997 and 1998 amounts reflect actual and projected expenditures by source of funding on a cash basis. Some expenditures reported in 1997, benefited the 1998 period. For 1999 and later years, operating costs are projected on an accrual basis and reflect estimates of actual costs to be incurred to provide services based on the projection assumptions listed below. Funding projections for future years are shown above at the 1999 level.

#### **Assumptions for Cost Projections:**

- **Hospitals will maintain current TB admission rates as a percentage of total TB cases in Texas.**
- **Outpatient visits are projected at 1997 levels.**
- **Average length of stay is projected to increase at 1/2% per year due to growth in MDRTB cases.**
- **The 1997 ratio of fixed and variable costs to total costs will remain consistent.**
- **Inflation is projected at 5 percent per year. (Note: Approximately fifty percent of operating costs is for salaries. Future salaries increases will depend on legislative action.)**
- **Relative source of funding is projected in proportion to 1997 actual amounts and adjusted for any changes in service mix.**
- **Actual historical DISPRO funding levels were provided by TDH staff. Future DISPRO levels are projected based on historical DISPRO payments as a percentage to total payments to the State. The actual DISPRO amount received in future years by this facility will depend on patient volumes for Medicaid patients and for patients without insurance.**
- **Any impact on this facility due to a reduction in services or due to the other TDH hospital closing, is expected to be phased in over a transitional period with the full impact not reflected in the above projections until 2001.**

**NOTE: Based on discussions conducted during the course of this study between the Commissioner and executive management of the TDH and the UTHC-Tyler and the consultant team, there is general consensus that the UTHC-Tyler could assume overall management of both TCID and STH with support from other UT Health System providers to augment the provision of medical and surgical care at STH. Both organizations recognize that numerous details would be subject to Legislative approval and direction, including but not limited to appropriations of operating funds, provision for debt service on capital expenditures, transfer of agency personnel, scope of services to be provided by TCID and STH, including at least research, medical education, and medical and surgical services.**

#### **Rationale for University of Texas Health Center-Tyler assuming overall management:**

**This change would promote an integrated State administered inpatient TB management strategy to encourage a seamless provision of TB inpatient care which incorporates medical education, research, and improved quality of care and allow for the State to continue to**

generate the DISPRO funds to the State. It is envisioned that the UTHC-Tyler location would focus on short-term acute care, complication management and surgery for TB services. The continuum of inpatient TB care would be provided through the TCID configuration as a long-term subacute care hospital with support services. Additionally, UTHC-Tyler would manage STH as a binational treatment center that would support TB services including MDRTB care and treatment, and selected medical, surgical and support services. Quarantine could be continued at TCID. Other services at TCID and STH would continue through interagency affiliations, teaching affiliations, research grants, and on-site clinic support. UTHC-Tyler has a modern, JCAHO accredited hospital with a self contained TB unit of 29 beds with potential expansion capability to 50 beds.

The total financial impact of having UTHC-Tyler versus TDH in the leadership role would be subject to the detailed agreements. It is anticipated that some economies of scale could be achieved by consolidating administration. Cost differentials would need to be determined in effecting a transfer of management.

The public policy decision for accepting the option to maintain and renovate both hospitals involves comparing the costs presented above to the benefits and impact on the following criteria. Keeping both locations will have the following impact whether the hospitals are managed by TDH or UTHC-Tyler.

## **1. Health Policy**

- a) Allows continuation of State's role as an expert health care provider for TB services across the state, including an urban, rural, and border safety-net for TB care.
- b) Allows continuation of state-supported women's health lab and research lab activities in San Antonio and/or in new locations.
- c) Allows continuation of State's role of providing court ordered TB quarantine services in San Antonio (approx. 2 new referrals per month with an average daily census of approximately 15 patients).
- d) Allows State to continue role of indigent health care service provider for the South Texas area of the Lower Rio Grande Valley which currently is not served by a local public hospital. This area is the largest metropolitan area in Texas without a local tax-supported hospital district.

## **2. Clinical**

- a) Allows State to directly apply uniform admission criteria, clinical protocols, utilization review, research and quality assurance for the delivery of TB care.
- b) Meets the clinical criteria developed by TDH.
- c) Maintains a cadre of experienced clinicians who have sufficient experience managing complicated TB cases so that they are truly experts in the field.

### **3. Economic**

- a) Allows for the provision of services at an operating cost which is substantially offset by DISPRO payments generated to the State.
- b) Continues the provision of public employment to the community.
- c) Continues to reduce local tax burden for communities from which patients are currently referred to the hospitals.
- d) Requires substantial expenditures for facility replacement or renovations in order to maintain JCAHO accreditation for STH and TCID.

### **4. Local Community Expectations**

- a) Allows for continuation of State jobs now provided at both locations.
- b) Provides financial relief to communities from which patients are currently referred to the hospitals.
- c) Provides supplemental safety net for selective medical and surgery services in the Valley.

## **Option B**

Option B retains both TCID and STH but eliminates the provision of medical and surgical services currently provided at STH. In addition to the impact analysis presented to Option A, the following impact should be noted regarding the elimination of medical and surgical services at STH. The STH currently provides medical and surgical services to a number of medically indigent persons in the Lower Rio Grande Valley who need both inpatient and outpatient hospital services, but their need is not an emergency condition which would provide them access to other hospitals in the Valley. The Lower Rio Grande Valley is currently the largest population center in the State without a locally funded hospital district to fill the gap for medical and surgical non-emergency patient care services. Therefore, the most significant impact of this model is that medical and surgical non-emergency services will be reduced to the medically indigent population in the Lower Rio Grande Valley.

The following financial illustration is presented which reflects the reduction in renovation costs for STH and the reduction in the costs for the provision of medical and surgical services which would no longer be available at STH. Additionally, DISPRO will be affected by this option.

The public policy decision for accepting the option to maintain and renovate both hospitals involves comparing the costs to the benefits and assessing the impact on the below criteria. Keeping both locations but providing services only for TB and other infectious diseases will have the following impacts whether the hospitals are managed by TDH or UTHC-Tyler.

### **1. Health Policy**

- a) Allows continuation of the State's role as an expert health care provider for TB services across the State, including an urban, rural, and Border safety net for TB care.

- b) **Allows continuation of a state-supported women's health lab as well as research lab activities in San Antonio and/or in new locations.**
- c) **Allows continuation of the State's role of providing court-ordered TB quarantine services in San Antonio (approximately two new referrals per month with an average daily census of approximately 15 patients).**

**2. Clinical**

- a) **Allows the State to directly apply uniform admission criteria, clinical protocols, utilization review, research, and quality assurance for the delivery of TB care.**
- b) **Maintains a cadre of experienced clinicians who have sufficient experience managing complicated TB cases so that they are truly experts in the field.**
- c) **Unless local sources of service are located, significant numbers of persons unable to access services currently provided at STH must leave the area for UTMB-Galveston or UT-M.D. Anderson for those services, or risk late or no treatment for their conditions. Delay of treatment is a significant factor in both increased patient morbidity and mortality.**

**3. Economic**

- a) **Allows for the provision of services at an operating cost which is partially offset by DISPRO payments generated to the State.**
- b) **Continues the provision of public employment to the community.**
- c) **Requires less substantial expenditures for facility replacement or renovations in order to maintain JCAHO accreditation for STH and TCID than does option A, due to selective renovation at STH.**

**4. Local Community Expectations**

- a) **Allows for continuation of State jobs now provided at both locations; however, fewer staff would be needed at STH.**

**The financial projections on the following two pages illustrate this option.**

TCID Cost Projections (Millions)	
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1998 - 2017
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[illegible]

### STH Cost Projections - TB Only (Millions)

1998 - 2017

[illegible]

### **Assumptions for Cost Projections:**

- **Hospitals will maintain current TB admission rates as a percentage of total TB cases in Texas.**
- **Outpatient visits are projected at 1997 levels.**
- **Average length of stay is projected to increase at 1/2% per year due to growth in MDRTB cases.**
- **The 1997 ratio of fixed and variable costs to total costs will remain consistent.**
- **Inflation is projected at 5 percent per year. (Note: Approximately fifty percent of operating costs is for salaries. Future salaries increases will depend on legislative action.)**
- **Relative source of funding is projected in proportion to 1997 actual amounts and adjusted for any changes in service mix.**
- **Actual historical DISPRO funding levels were provided by TDH staff. Future DISPRO levels are projected based on historical DISPRO payments as a percentage to total payments to the State. The actual DISPRO amount received in future years by this facility will depend on patient volumes for Medicaid patients and for patients without insurance.**
- **Any impact on this facility due to a reduction in services or due to the other TDH hospital closing, is expected to be phased in over a transitional period with the full impact not reflected in the above projections until 2001.**

### **Options C, D, and E**

*These options would combine the services of the two TDH hospitals into one of the existing locations and maintain state management of the combined operation by either TDH or the University of Texas Health Center - Tyler.*

**If the transportation barriers could be overcome, either STH or TCID could manage the capacity for their current combined inpatient TB services. However, neither hospital provides TB surgical services. Additionally, TCID provides no general surgical services and it is highly questionable as to whether persons from the Lower Rio Grande Valley will continue to have access to non-emergency medical and surgical services even if the services are offered in San Antonio. It should be noted that a viable public transportation system linkage between San Antonio and the Lower Rio Grande Valley does not exist.**

**There will be a loss of DISPRO funding for the closure of either hospital which impacts the feasibility of this option. There also are problems relating to transfer of non-U.S. citizens currently being served in STH at an interior location because non-citizen patients without legal immigrant status cannot be transported beyond the INS checkpoints.**

**This report presents three consolidation scenarios for review.**

**Option C. Retain STH and close TCID with STH continuing to provide TB, medical, surgical and support services.**

**Option D. Retain STH and close TCID with STH continuing to provide only TB inpatient services.**

**Option E. Retain TCID and close STH.**

**Option C: Retain STH and close TCID with STH continuing to provide TB, medical, surgical and support services.**

Policy decisions will be required to determine whether to retain the current women's lab activities at the current TCID site, outsource these activities, or consolidate the services elsewhere in San Antonio or in Austin at the TDH central lab. A decision would also need to be made as to where to locate the research activities which are currently performed. These functions might be located in UTHC-Tyler, relocated within San Antonio or based at some other research site. Closing TCID would also have the greatest impact on the TB inpatients since of the three state administered TB hospitals, TCID currently has the highest average daily census of TB patients.

It should be noted that a legal issue affects the transportation of TB patients. The law requires that proper isolation methods be used and medical care be made available for these patients. This requires direct point-to-point transportation to an inpatient facility equipped to deal with such patients. There can be no overnight stops in unequipped facilities due to disease transmission risks. This poses a significant logistical challenge for a state as large as Texas.

This option will affect TDMHMR. Current operational efforts are shared at the campus including the provision of utilities and the operation of the steam plant requiring six full time equivalent staff.

To illustrate costs for this option, the following financial summary is presented.

STH Cost Projections with TCID Admissions (Millions)									
1998 - 2017									
	Actual 1997 See Note Below	Projected 1998 See Note Below	1999	2000	2001	2002	5 Yr. Period 2003 - 2007	5 Yr. Period 2008 - 20012	5 Yr. Period 2013 - 2017
<b>Operating Cost Summary</b>									
Inpatient			\$ 9.46	\$ 9.79	\$ 15.30	\$ 15.88	\$ 89.31	\$ 109.87	\$ 137.22
Outpatient			3.78	3.97	4.29	4.50	26.12	33.33	42.54
Other			1.21	1.27	1.34	1.40	8.14	10.38	13.25
<b>Total Operating Cost</b>	\$ 14.46	\$ 13.08	\$ 14.46	\$ 15.03	\$ 20.92	\$ 21.78	\$ 123.56	\$ 153.59	\$ 193.01
<b>Method of Finance</b>									
<b>TDH Hospitals Strategy</b>									
G/R Rev. Appropriation	\$ 6.92	\$ 7.90	\$ 7.90	\$ 7.90	\$ 17.91	\$ 17.91	\$ 89.57	\$ 89.57	\$ 89.57
G/R Rev. Trans.BOH Approved	2.90	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Federal Funds	0.00	0.00	0.00	0.00	0.51	0.51	2.56	2.56	2.56
Fees and Receipts	2.14	2.63	2.63	2.63	3.53	3.53	17.65	17.65	17.65
<b>Prevent. Disease Strategy</b>	0.28	0.29	0.29	0.29	0.54	0.54	2.69	2.69	2.69
<b>M&amp;CH Strategy</b>									
General Revenue	0.81	0.84	0.84	0.84	0.84	0.84	4.20	4.20	4.20
<b>Employee Benefits</b>									
G/R (Appropriated to ERS)	0.95	0.96	0.96	0.96	2.27	2.27	11.36	11.36	11.36
Fees and Receipts	0.46	0.46	0.46	0.46	0.76	0.76	3.80	3.80	3.80
Federal Funds			0.00	0.00	0.03	0.03	0.17	0.17	0.17
<b>Total Method of Finance</b>	\$ 14.46	\$ 13.08	\$ 13.08	\$ 13.08	\$ 26.40	\$ 26.40	\$ 131.98	\$ 131.98	\$ 131.98
<b>Funding (Overage) Shortfall</b>	\$ -	\$ -	\$ 1.38	\$ 1.96	\$ (5.47)	\$ (4.62)	\$ (8.43)	\$ 21.60	\$ 61.03
<b>Dispro</b>									
State	\$ 3.26	\$ 3.48	\$ 3.37	\$ 2.86	\$ 2.70	\$ 2.70	\$ 13.49	\$ 13.49	\$ 13.49
Federal	5.54	5.92	5.74	4.87	4.59	4.59	22.96	22.96	22.96
<b>Total Dispro</b>	\$ 8.80	\$ 9.40	\$ 9.11	\$ 7.72	\$ 7.29	\$ 7.29	\$ 36.45	\$ 36.45	\$ 36.45
<b>Capital Costs</b>									
<b>Option 1</b>									
Total Renovation (Kennedy Report)			\$ 18.60						
Annual Debt Service*				\$ 1.77	\$ 1.77	\$ 1.77	\$ 8.83	\$ 8.83	\$ 3.53
<b>Option 2</b>									
New Hospital			\$ 26.00						
Annual Debt Service*				\$ 2.47	\$ 2.47	\$ 2.47	\$ 12.34	\$ 12.34	\$ 4.94
* Annual Debt Service is at 5 percent amortized over 15 years.									
NOTE: 1997 and 1998 amounts reflect actual and projected expenditures by source of funding on a cash basis. Some expenditures reported in 1997, benefited the 1998 period. For 1999 and later years, operating costs are projected on an accrual basis and reflect estimates of actual costs to be incurred to provide services based on the projection assumptions listed below. Funding projections for future years are shown above at the 1999 level.									

### **Assumptions for Cost Projections:**

- **Hospitals will maintain current TB admission rates as a percentage of total TB cases in Texas.**
- **Outpatient visits are projected at 1997 levels.**
- **Average length of stay is projected to increase at 1/2% per year due to growth in MDRTB cases.**
- **The 1997 ratio of fixed and variable costs to total costs will remain consistent.**
- **Inflation is projected at 5 percent per year. (Note: Approximately fifty percent of operating costs is for salaries. Future salaries increases will depend on legislative action.)**
- **Relative source of funding is projected in proportion to 1997 actual amounts and adjusted for any changes in service mix.**
- **Actual historical DISPRO funding levels were provided by TDH staff. Future DISPRO levels are projected based on historical DISPRO payments as a percentage to total payments to the State. The actual DISPRO amount received in future years by this facility will depend on patient volumes for Medicaid patients and for patients without insurance.**
- **Any impact on this facility due to a reduction in services or due to the other TDH hospital closing, is expected to be phased in over a transitional period with the full impact not reflected in the above projections until 2001.**

**Following are the impacts that this option will have against the criteria which should be considered in weighing costs to benefits.**

**If STH is retained and TCID closes, the following findings apply:**

#### **1. Health Policy**

- a) **Allows continuation of State's role as a health care provider for TB services and selected medical and surgical services.**
- b) **Requires relocation or outsourcing for the provision of the TDH women's health lab and research lab activities housed at San Antonio.**
- c) **With a redesignation, allows continuation of State's role of providing court ordered TB services at South Texas instead of the current San Antonio site.**
- d) **Allows State to continue its role of an health care service provider for many medically indigent persons in South Texas which currently is not served by a local public hospital.**

## **2. Clinical**

- a) Allows State to directly apply uniform admission criteria, clinical protocols, utilization review, research and quality assurance for the delivery of TB care.**
- b) Could significantly impact availability of inpatient capacity for medical and surgical cases.**
- c) Significant renovation and management requirements are needed to safely mix medical/surgical and non-infectious TB patients on same nursing unit.**
- d) Increases patient transportation distance and cost, possibly increasing risk of transmission of disease.**
- e) Maintains a cadre of experienced clinicians who have sufficient experience in managing complicated TB cases that they are truly experts in the field.**

## **3. Economic**

- a) Allows for the provision of services at an operating cost which is substantially offset by DISPRO payments made to the State.**
- b) Requires renovation expenditures for only one of the two hospitals in order to maintain State JCAHO accreditation capacity.**
- c) Reduces DISPRO payments currently generated to the State general fund.**

## **4. Local Community Expectations**

- a) Eliminates 300+ State jobs in San Antonio, partially mitigated by transfers to STH for service enhancements at that facility.**
- b) Requires additional financial burden on those communities unable to continue to refer indigent patients for logistical reasons to the remaining South Texas location.**
- c) A significant number of the referrals each year to TCID currently come from Harris, Travis, and Bexar counties each of which has public hospital capacity. These counties currently receive large amounts of DISPRO payments for the provision of indigent care and logically could be expected to provide for services to patients treated at TDH hospitals. However, DISPRO payments have recently declined and are projected to be reduced over the next five years; managed care pressures are significant for local public hospitals; and local tax support often limits more regional approaches by not accepting out-of-county medically indigent patients.**

**Option D: Retain STH and close TCID with STH continuing to provide only TB inpatient services.**

**As previously described under Option B, this scenario poses access problems for those persons in the Lower Rio Grande Valley who are medically indigent and need non-emergency inpatient and outpatient hospital services. The option, however, does reduce the renovation costs to bring STH into compliance with accreditation standards and reduces the operating costs due to the elimination of medical and surgical services.**

**The following financial projections illustrate this scenario.**

## 1998 - 2017

NOTE: 1997 and 1998 amounts reflect actual and projected expenditures by source of funding on a cash basis. Some expenditures reported in 1997, benefited the 1998 period. For 1999 and later years, operating costs are projected on an accrual basis and reflect estimates of actual costs to be incurred to provide services based on the projection assumptions listed below. Funding projections for future years are shown above at the 1999 level.

### **Assumptions for Cost Projections:**

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- **The 1997 ratio of fixed and variable costs to total costs will remain consistent.**
- **Inflation is projected at 5 percent per year. (Note: Approximately fifty percent of operating costs is for salaries. Future salaries increases will depend on legislative action.)**
- **Relative source of funding is projected in proportion to 1997 actual amounts and adjusted for any changes in service mix.**
- **Actual historical DISPRO funding levels were provided by TDH staff. Future DISPRO levels are projected based on historical DISPRO payments as a percentage to total payments to the State. The actual DISPRO amount received in future years by this facility will depend on patient volumes for Medicaid patients and for patients without insurance.**
- **Any impact on this facility due to a reduction in services or due to the other TDH hospital closing, is expected to be phased in over a transitional period with the full impact not reflected in the above projections until 2001.**

**The public policy decision for accepting the option to renovate only STH involves comparing the costs to the benefits and assessing the impact on the below criteria. Keeping only STH and providing only TB services will have the following impacts whether the hospital is managed by TDH or UTHC-Tyler.**

#### **1. Health Policy**

- a) **Allows continuation of the State's role as an expert provider of TB services across the state as well as an urban, rural, and Border safety net for TB care.**
- b) **Requires discontinuation or relocation to another entity of State-supported women's health lab and research lab activities in San Antonio.**
- c) **Allows continuation of the State's role of providing court-ordered TB quarantine services in STH instead of TCID (approximately two new referrals per month with an average daily census of approximately 15 patients).**
- d) **Reduces expenditures for facility replacement or renovations in order to maintain JCAHO accreditation for only STH.**
- e) **Discontinues TDH role of indigent health care service provider for the**

**Lower Rio Grande Valley, which contains the largest metropolitan area in Texas without a local tax-supported hospital.**

- f) Requires special rule making or agreements with INS for transfer of non-US citizens; or implementation of enhanced inpatient services in Mexico and binational accords for patients seen and treated in the US to be referred to Mexico for care.**

## **2. Clinical**

- a) Allows State to directly apply uniform admission criteria, clinical protocols, utilization review, research and quality assurance for the delivery of TB care.**
- b) Unless local sources of service are located, significant numbers of persons unable to access services currently provided at STH must leave the area for UTMB-Galveston or UT-M.D. Anderson for those services, or risk late or no treatment for their conditions. Delay of treatment is a significant factor in both more patient morbidity and mortality.**
- c) Maintains a cadre of experienced clinicians who have sufficient experience managing complicated TB cases so that they are truly experts in the field.**

## **3. Economic**

- a) Allows for the provision of services at an operating cost which is substantially offset by DISPRO payments generated to the State.**
- b) Continues the provision of public employment to the community, but to a lesser extent.**
- c) Requires reduced expenditures for facility replacement or renovations in order to maintain JCAHO accreditation for only STH.**

## **4. Local Community Expectations**

- a) Allows for continuation of State jobs at only one of the current two locations.**

**Option E: Retain TCID and close STH.**

**In addition to the access issues previously described under Options B and D, the closure of STH will create access barriers for TB patients in addition to those persons who are medically indigent and need non-emergency inpatient and outpatient hospital services. While TB patients usually have longer lengths of stay than medical and surgical patients, the transporting of non-U.S. citizens currently being served in STH will require special rule making and/or agreements with the INS. However, this option does reduce the total amount of renovation costs and reduces the projected operating costs since the medical and surgical services at STH will no longer be provided.**

**The following financials are presented to illustrate this option.**

### TCID Cost Projections with STH TB Admissions (Millions)

1998 - 2017

[illegible]

### **Assumptions for Cost Projections:**

- **Hospitals will maintain current TB admission rates as a percentage of total TB cases in Texas.**
- **Outpatient visits are projected at 1997 levels.**
- **Average length of stay is projected to increase at 1/2% per year due to growth in MDRTB cases.**
- **The 1997 ratio of fixed and variable costs to total costs will remain consistent.**
- **Inflation is projected at 5 percent per year. (Note: Approximately fifty percent of operating costs is for salaries. Future salaries increases will depend on legislative action.)**
- **Relative source of funding is projected in proportion to 1997 actual amounts and adjusted for any changes in service mix.**
- **Actual historical DISPRO funding levels were provided by TDH staff. Future DISPRO levels are projected based on historical DISPRO payments as a percentage to total payments to the State. The actual DISPRO amount received in future years by this facility will depend on patient volumes for Medicaid patients and for patients without insurance.**
- **Any impact on this facility due to a reduction in services or due to the other TDH hospital closing, is expected to be phased in over a transitional period with the full impact not reflected in the above projections until 2001.**

**The public policy decision for accepting the option to maintain and renovate only TCID and only provide TB services involves comparing the costs to the benefits and assessing the impact on the below criteria. Keeping only TCID will have the following impacts whether the hospital is managed by TDH or UTHC-Tyler.**

#### **1. Health Policy**

- a) Allows continuation of State's role as an expert health care provider for TB services across the State, including an urban, rural, and border safety-net for TB care.**
- b) Allows continuation of state-supported women's health lab and research lab activities in San Antonio and/or in new locations.**
- c) Allows continuation of State's role of providing court ordered TB quarantine services in San Antonio (approximately 2 new referrals per month with an average daily census of approximately 15 patients).**

- d) Removes TDH from the role of indigent health care services provider for the South Texas area of the Lower Rio Grande Valley which currently is the largest population area in Texas without a local tax supported hospital district.
- e) Requires substantial expenditures for facility replacement or renovations in order to maintain JCAHO accreditation for TCID.
- f) Requires special rulemaking and/or agreements with INS for transfer of non-U.S. citizens; or implementation of enhanced inpatient services in Mexico and binational accords for non-citizen patients seen and diagnosed in the U.S. to be referred to Mexico for care.

## **2. Clinical**

- a) Allows State to directly apply uniform admission criteria, clinical protocols, utilization review, research and quality assurance for the delivery of TB care.
- b) Unless local sources of service are located, significant numbers of persons unable to access services currently provided at STH must leave the area for UTMB-Galveston or UT-MD Anderson for those services, or risk late or no treatment for their conditions. Delay of treatment is a significant factor in both more patient morbidity and mortality.
- c) Maintains a cadre of experienced clinicians who have sufficient experience managing complicated TB cases so that they are experts in the field.

## **3. Economic**

- a) Allows for the provision of services at an operating cost which is partially offset by DISPRO payments generated to the State.
- b) Continues the provision of public employment to the San Antonio community but removes a major payroll from the Lower Rio Grande Valley.
- c) Requires substantial expenditures for facility replacement or renovations in order to maintain JCAHO accreditation for TCID.

## **4. Local Community Expectations**

- a) Removes TDH from the role of indigent health care services provider for the South Texas area of the Lower Rio Grande Valley which currently is the largest population area in Texas without a local tax supported hospital district.
- b) Continues the provision of public employment to the San Antonio community but removes a major public payroll from the Lower Rio Grande Valley.

## **Option F:**

*Outsource the operations of either and/or both of the TDH hospitals to non-state facilities.*

It is important to note that this option lacks some of the net state cost benefit because of the DISPRO dollars projected to be available to both of the TDH hospitals over the next five years and perhaps for additional years. However, the State could cap its financial effort by awarding grant funds to selective hospitals or other providers like clinics or private laboratories versus attempting to purchase services via a fee for service basis. Hospitals are reluctant to assume inpatient responsibility for high risk, long length of stay, and high total cost groups when given a choice.

Inpatients admitted for chronic conditions and/or as a result of non-compliant behavior, and outpatients with TB, Hansen's Disease and other chronic conditions are not perceived as a marketing asset in today's highly competitive healthcare environment. The availability of adequate services and maintaining budget predictability becomes a public policy question under this option. Outsourcing the provision of inpatient TB hospital services from TCID and STH is of questionable current value from a State funding perspective because of the favorable DISPRO payments that TCID and STH are generating. Even if changes occur in the DISPRO funding system from the federal level, it may be anticipated that current methods may be used for at least a five- year forecast. DISPRO amounts are forecast for the two hospitals as follows:

1998	\$19.6 million
1999	\$19.0 million
2000	\$16.1 million
2001	\$15.2 million
2002	<u>\$15.2 million</u>
	<u>\$85.1 million</u>

Assuming a federal match ratio of approximately 63%, the net amount of federal DISPRO funds is approximately \$54 million. Closing these hospitals will have the effect of the State foregoing these federal dollars and will substantially reduce the amount of total dollars available for purchasing an equivalent amount of services from the private sector or will substantially increase the net State funding required. In essence, the DISPRO dollars are subsidizing the provision of services currently provided at these hospitals. In addition, despite the relatively low patient volumes for inpatient TB at the hospitals, the average per diem costs appear competitive even without the added DISPRO funding benefit to the State, based on a review of costs provided by TDH for area hospitals. (See Appendix J)

If the State elected this option, the following impact would need to be considered.

## **1. Health Policy**

- a) **Contractual agreements must be made with an appropriate provider(s) of services to guarantee access and define reimbursement amounts and methods for inpatient TB services. In South Texas this option leaves part of the**

population at risk for loss of access to non-emergency medical and surgical services.

- b) Changes State role for these locations from provider of TB and medical and surgical services to a role of purchaser/monitor of services.
- c) Requires State to make operating decisions regarding the operation of the women's lab and research lab services in San Antonio and lab functions in Harlingen.
- d) Requires a statewide examination of entitlement criteria and eligibility issues for patients requiring services provided at the TDH hospitals which will affect demand and budget predictability. Essentially, the State would have to create and define a new statewide entitlement program for inpatient TB management. A Valley-wide entitlement program for patients now served by STH would also need to be created.
- e) This option will affect TDMHMR and cause an impact to the Rio Grande State Center and San Antonio State School budgets.

## **2. Clinical**

- a) State will need to establish entitlement program guidelines to define admission criteria, financial criteria, clinical protocols, utilization review, research and quality assurance for the delivery of TB care.
- b) Acute hospitals are not built to provide long-term chronic patient management such as required for TB patients. Nor are they prepared to serve "hard-to-treat" and "hard-to-manage" (non-compliant) patients which require special security and psychosocial considerations.
- c) Private sector facilities providing TB inpatient care will have to meet new OSHA standards beginning January 1, 1999. These new standards for TB treatment are require 20 air changes per hour and 100% exhaust if a patient is suspected ore known to be infectious. This requirement will apply to all areas of the facility where a TB patient may receive care including surgery, radiology, clinic areas, etc. Implementation is anticipated to be expensive.
- d) Lose highly experienced clinician base if outsourcing is spread among several hospitals, since individual caseload and experience would decrease.

## **3. Economic**

- a) The federal share of DISPRO payments will no longer be available to the State general fund.
- b) Costs subject to contract negotiations creating a lack of budget predictability.
- c) Financial eligibility for indigent health care services becomes a major issue for both TB services on a statewide basis and in South Texas for non TB services, especially for non-citizens without documented status.
- d) Renovation expenditures in order to maintain JCAHO accreditation no longer

**required.**

- e) Places additional financial burden on local governments currently benefiting from state funded services.**

#### **4. Local Community Expectations**

- a) State jobs eliminated both in San Antonio and South Texas.**
- b) Local funding burden potentially increased for Valley and communities currently referring patients to the hospitals.**
- c) Loss of health care services for persons who are medically indigent, depending on State's willingness to establish state and regional entitlement programs.**